Washington State Health Care Authority

Tribal Compliance & Operations Work Group

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HCA Tribal Affairs Office
October 12, 2016

Agenda

- Guest Speaker – Gail Kreiger, Managed Care Enrollment changes for January, 2017
- Guest Speaker – Heather Weiher, Maternity Support Services changes for January, 2017
- Disclosure Requirements for ITUs – CMS answer
- Reducing duplicate claim submissions
- HCA Coordination of Benefits contact update
- ProviderOne Update: MCO wraparounds
- ProviderOne Update: Multiple encounters
- ProviderOne Update: Duplicate rejections
- Top 5 denials
- FAQ and Open Discussion

Managed Care Enrollment changes for January, 2017

Managed Care Enrollment Change for January 2017

- Clients who have private insurance (according to P1) have historically not been enrolled in an MCO
- Beginning 01/01/2017 clients who have private insurance (according to P1) will be enrolled in an MCO
- HCA will be working with the plans to ensure that IHS CHS/PRC is the payer of last resort
- Claims will be billed to private insurance, then MCO, then P1 for balance of IHS rate (Urban orgs bill private insurance then MCO)

NOTE: AI/AN clients continue to have the elective exemption from MCO enrollment

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Maternity Support Services (MSS)

Heather Weiher
First Steps Program Manager
MPOI
October 12, 2016

What is MSS?

- Voluntary program
- Designed to provide prevention health and education services, basic health messages, and brief interventions to clients
- Purpose:
  - Improve and promote healthy birth outcomes
  - Help clients access:
    - Prenatal care as early in pregnancy as possible
    - Health care for eligible infants

MSS Goals

Increase:

- Early access and ongoing use of prenatal and newborn care
- Initiation and duration of breastfeeding

MSS Goals

Decrease:

- Maternal and infant morbidity and mortality rates
- Low birth-weight babies
- Premature births
- Health disparities
- Number of unintended pregnancies and repeat pregnancies within 2 years of delivery
- Tobacco and nicotine use during pregnancy and pediatric exposure to second-hand smoke

MSS Eligibility

- A client must be:
  - Pregnant or within 60 days postpartum
  - Receiving Washington Apple Health (Medicaid)
- Clients enrolled in managed care are eligible for MSS outside of their plan

MSS Covered Services

- In-person screening(s) for risk factors
- Brief counseling
- Education related to improving pregnancy and infant health outcomes
- Interventions for risk factors
- Basic health messages
- Referral to community resources
- Case management and care coordination

MSS Interdisciplinary Team

- Community Health Nurse (RN)
- Behavioral Health Specialist (BHS)
- Registered Dietitian (RD)
- Community Health Representative (CHR)

Exception for Tribes and Indian Health Programs

- A Tribe or Indian Health Program must have at least one of the following team members:
  - Behavioral health specialist
  - Registered dietitian
  - Community health nurse (RN)

CHR Requirements

- Have a high school diploma or equivalent
- Have a minimum of one year of health care and/or social services experience
- Complete a training plan developed and implemented by the agency
- Carry out all activities under the direction or supervision of the RN, BHS, or RD

Level of Services

- Billed to ProviderOne in 15 minute increments*
- A client is eligible for a maximum of 6 units per day
- All pregnant women who are American Indian/Alaskan Native are automatically eligible for the maximum of 30 units (7 hours and 30 minutes)

*except for group services

Reimbursement for RN, BHS & RD

- Office
  - $25 per unit
- Home or alternate site
  - $35 per unit

➢ Total maximum reimbursement for each pregnant woman could be up to $1,050

Reimbursement for CHR

- Office
  - $14 per unit
- Home or alternate site
  - $18 per unit

MSS Group Services

- Provided by RN, BHS, or RD
- 1 units per client per day
- Reimbursed $25 per client
- Must be no less than one hour
- 3 to 12 clients must be in attendance

Upcoming Change January 1, 2017

MSS provided by a BHS is encounter eligible

- Billing
  - Procedure code 96152
  - Billing/Group NPI – Agency's NPI
  - Billing/Group taxonomy – 208D00000x (Medical)
  - Servicing/Performing NPI – **Agency's NPI**
    - *Individual servicing NPIs are not used on MSS claims*
  - Servicing/Performing taxonomy – 171M00000x

Questions?

More Information:

http://hca.wa.gov/billers-providers/programs-and-services/first-steps-maternity-and-infant-care

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Disclosure Requirements for ITUs – CMS answer

CMS Disclosure Rule 42 C.F.R. § 455.104

- Disclosure Requirements on Ownership and Control
- MCOs requiring Indian Health Care Providers (IHCPs) to provide ownership and control disclosures
- HCA received multiple complaints that IHCPs are exempt – referred to Federal Register 76-22
- HCA sought guidance from CMS in April 2015

CMS Disclosure Rule 42 C.F.R. § 455.104

- Last week, CMS confirmed that IHCPs are required to provide the disclosures in 42 C.F.R. § 455.104
- Most IHCPs will have disclosure requirements for the "managing employee"
  - Who: General manager, business manager, administrator, director, or other individual who exercises operational or managerial control of the clinic (not Tribal council or Tribal chair)
  - What: Name, address, date of birth, and SSN

Reducing duplicate claim submissions

Claims Analysis

- To help I/T/Us with billing issues, HCA often completes claims analysis and gives the individual I/T/U feedback on claim denials
- A claims analysis involves HCA reviewing denied claims and paid claims that did not pay at the full encounter rate
- While duplicate claims submissions do not have a financial impact on an I/T/U, they do significantly increase the amount of time required to perform a claims analysis
- To support HCA's continued ability to conduct claims analysis of every I/T/U, please make sure that the original TCN is being *replaced* rather than submitting a new claim whenever a claim needs to be reprocessed

Contacting HCA's Coordination of Benefits and Patient Review Coordination Offices

Contacting HCA's Coordination of Benefits and Patient Review Offices

- Phone calls to the Coordination of Benefits (COB) office are now routed through HCA's Medical Assistance Customer Service Center for triage. You may continue to call 1-800-562-3022 ext. 16134 or fax directly to COB at 360-586-3005
- The Patient Review and Coordination office (PRC, for clients under review) may be reached at 1-500-562-3022 ext. 51100
- You may also use the Contact Us link at *https://fortress.wa.gov/hca/p1contactus/*
  - Menu items include Authorization, Billing/Policy, Claim Denial, Client Eligibility Clarification, Create Template/Batch, Ordering-Referring-Prescribing, Private Commercial Insurance, Provider Enrollment, Service Limits, Mental Incapacity Evaluation, Other, SUD AI/AN FFS Program update
- I/T/U providers are always welcome to contact Tribal Affairs – call or email mike

ProviderOne Claims Issue – MCO Wraparounds

- Background information presented in 09/14/2016 TCOW
- P1 is currently rejecting correctly billed MCO wraparound claims in error with EOB 24: "*Charges are covered under a capitation agreement/managed care plan*"
- Mike is submitting ongoing mass adjustments to correct erroneous denials
- System techs are working on a permanent resolution (possibly late November 2016)

ProviderOne Claims Issue – Multiple Encounters

- Background information presented in 09/24/2016 TCOW
- Claims that have multiple units on the T1015 line are currently paying as FFS only (rejecting the T1015 line with EOB N362)
- Please contact Mike if you have any claims for multiple encounters that are not paying correctly
- Mike is submitting ongoing mass adjustments to correct erroneous payments or denials
- System techs are working on a permanent resolution (no ETA yet)

ProviderOne claims Issue – Duplicate Rejections

- P1 is currently rejecting some encounters with EOB B20: *"Procedure/service was partially or fully furnished by another provider"* if there was an encounter previously paid under a different category. This should be payable because clients are allowed one of each categorical encounter per day.
- Limited dental evaluations (D0140) are also being rejected with B20 if client received an evaluation at a different clinic. This is also payable.
- Mike is submitting ongoing mass adjustments to correct erroneous payments or denials.
- System techs working on a permanent resolution (possibly late November 2016)

Medical - Top 5 Rejections

EOB	Description	Comments	Denial %
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Claim missing the UA or SE modifier	12%
24	Charges are covered under a capitation agreement/managed care plan	Client is enrolled in MCO	12%
16 / M54	Missing/incomplete/invalid total charges	HIPAA claims only – the total billed amount was not equal to the sum of the lines	8%
204	This service/ equipment/drug is not covered under the patient's current benefit plan	Clients were Medicare-only	5%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	4%

Dental - Top 5 Rejections

EOB	Description	Comments	Denial %
204	This service/ equipment/drug is not covered under the patient's current benefit plan	Clients were Medicare-only	8%
18	Exact duplicate claim/service	Duplicate	8%
6	The procedure/revenue code is inconsistent with the patient's age.	Crowns and (posterior) root canals not payable for adults	6%
16/ M53	Missing/ incomplete/ invalid days or units of service	Units are required on the billing code line(s). Claims are being received with 0 units	5%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	This is a best-fit EOB. Claim was missing the EPA AI/AN client 870001305 Non-AI/AN client 870001306	5%

Mental Health - Top 5 Rejections

EOB	Description	Comments	Denial %
204	This service/equipment/drug is not covered under the patient's current benefit plan	Servicing taxonomy issues, see EOB 204 in the September TCOW	25%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	Performing (*rendering, servicing*) provider not in P1	12%
24	Charges are covered under a capitation agreement/ managed care plan	Client is enrolled in MCO	10%
96 / N30	Patient ineligible for this service	Client is Medicare Only	9%
16 / N288	Missing/incomplete/invalid rendering provider taxonomy	Performing (*rendering, servicing*) taxonomy on claim is not a taxonomy that the performing provider is enrolled with	7%

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SUD - Top 5 Rejections

EOB	Description	Comments	Denial %
204	This service/ equipment/drug is not covered under the patient's current benefit plan	SUD claims were billed with individual servicing NPIs. SUD claims are only billed with facility NPI/taxonomy	10%
16/ N290	Missing/incomplete/ invalid rendering provider primary identifier	SUD claims were billed with individual servicing NPIs. SUD claims are only billed with facility NPI/taxonomy	9%
170/ N95	This provider type/provider specialty may not bill this service	Most of the claims were UAs/lab codes or acupuncture. The only payable codes for SUD are in the SUD guide	9%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	SUD claims have modifier requirements for the SUD codes. I/T/U claims will almost always have HF modifier on the SUD code (refer to SUD billing guide)	8%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	I/T claims also need modifier on the T1015 line AI/AN client – HF nonNative ABP (RAC 1201) – SE nonNative SSI (RAC 1217) – HB nonNative classic (all other RACs) – HX	8%

FAQ and Open Discussion

Q. Pharmacists can now be billed at the same rate as ARNPs and PAs. Why doesn't HCA pay for the pharmacists doing clinical work?

A. PharmD's are eligible to perform the following services (FFS) on a professional claim (supplies, including DME are out of scope)

- Tobacco cessation for pregnant clients (physician billing guide)
- Clozaril case management (physician billing guide)
- Emergency contraception counseling (Pharmacy guide)
- Vaccine administration fee (Pharmacy guide)

Evaluation and Management (E&M 99201-99215) services are not included in HCA's list of services that should be payable for pharmacists. Per HCA's Quality Management/Clinical team, E&Ms are not within a pharmacist's scope of practice.

Note: Pharmacists are not eligible for the IHS or FQHC encounter rate

FAQ and Open Discussion

Q. Why did my claim for a preventive visit (CPT 99385/99395) reject due to client age? Code is for 18-39 years old and client is 30. Not only did the 99385 reject, but the entire claim was rejected.

A. P1 was updated on 09/23/2016 to resolve this issue.

Previously, CPT 99385/99395 caused the **entire claim** to become a well child visit, which is allowed for clients age 0-20. If the client is 21 or over, then the **entire claim** was rejected.

Starting 09/23/2016 (and retroactive), these claims will no longer become well child visits if the client is age 21 or over. CPT 99385/99395 is still not a covered service for adults, but, with this change, the rest of the claim is now payable.

FAQ and Open Discussion

Q. We need to add clinic employees to P1 so that they can check client eligibility for billing purposes. Is there anything restricting me from granting employees from other departments at the Tribe access to the P1 portal?

A. Employees may be added to the domains as long as they have legitimate business within the domain. Ensure that users have the appropriate security profile level. For example, an eligibility checker should only have the lowest-level “Eligibility Checker” profile in P1.

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FAQ and Open Discussion

Q. Does P1 pay for annual preventive cancer screens? G0101 with diagnosis Z00.00 was rejected?

A. Refer to page 133 of the Physician-Related Services/Health Care Professional Services Billing Guide at http://www.hca.wa.gov/assets/billers-and-providers/physician-related-services-bi-20161001.pdf

There are no diagnosis requirements established for these services; however, Z00.00 is in the list of generally not payable diagnoses

HCPCS Code	Short Description	Limitations
G0101	CA screen; pelvic/breast exam	Females only; As indicated by nationally recognized clinical guidelines. [Use for Pap smear professional services]
G0103	PSA screening	Once every 12 months when ordered for clients age 50 and older
G0104	CA screen; flexi sigmoidscope	Clients age 50 and older who are not at high risk Once every 48 months
G0105*	Colorectal scrn; hi risk ind	Clients at high risk for colorectal cancer One every 24 months
82270	Occult blood, feces	N/A
81519	Genomic testing (breast)	Requires EPA (see EPA #87001386).
G0121*	Colon CA scrn; not high risk ind	Clients age 50 and older Once every 10 years
G0122	Colon CA scrn; barium enema	Clients age 50 and older Once every 5 years
S8032	Low-dose computed tomography for lung cancer screening	Requires EPA (see EPA #870001362). If the client does not meet EPA criteria, PA is required (see Prior Authorization)

*Note: Per Medicare guidelines, the agency's payment is reduced when billed with modifier 53 (discontinued procedure).

FAQ and Open Discussion

Q. How can I tell if HCA has a diagnosis requirement for a medical service?

A. Refer to the Physician Related Services/Health Care Professional Services Billing Guide at http://www.hca.wa.gov/assets/billers-and-providers/physician-related-services-bi-20161001.pdf

Find the subsection that addresses the service. If there is a diagnosis requirement, it will either be listed in the section or there will be a pointer to the *Approved Diagnosis Codes by Program* web page at http://www.hca.wa.gov/assets/billers-and-providers/physician_related_professional.pdf

FAQ and Open Discussion

Q. There are birth control diagnoses (e.g. Z300.11) listed in the Generally Not Payable list of diagnoses. What code should we use instead?

A. The list of Generally Not Payable diagnoses does include some birth control diagnoses, and these are not payable on EPSDT (well child) claims. They are payable on regular Medical claims. Mike will try to recreate the list of generally not payable diagnoses for Medical only and omit EPSDT

FAQ and Open Discussion

Q. Did the CPT code for SUD individual therapy change? we were told to bill with 96154

A. The codes in SUD did change on 07/01/2015

SUD prior to 06/30/2015

96154-HF	[redacted]	Health and behavior intervention, family with patient present	Individual Therapy with Client Present
96155-HF	[redacted]	Health and behavior intervention, family without patient present	Individual Therapy Without Client Present
96153-HF	[redacted]	Health and behavior intervention, family without patient present	Group Therapy

SUD after 07/01/2015

H0004-HF	[redacted]	Behavioral health counseling and therapy, per 15 minutes	Individual Therapy Without Family Present
96153-HF	[redacted]	Health and behavior intervention, group (2 or more patients)	Group Therapy
96154-HF	[redacted]	Health and behavior intervention, family with patient present	Individual Family Therapy With Enrollee Present
96155-HF	[redacted]	Health and behavior intervention, family without the patient present	Individual Family Therapy Without Enrollee Present

Pended Questions

Q. During the June webinar, you listed out diagnosis codes that would waive the once-per-two-year vision exam limit. Why are only some of the diabetes diagnoses listed? Type II (E11.xx) is the most common category of diabetes within the AI/AN population, and I believe that the standard of care is that diabetic patients, regardless of the cause of the DM have an annual eye exam. This shouldn't be determined if the symptoms are in control or not because retinopathy can be found during an annual eye exam even with a patient that has very good control over their glucose. If it wasn't necessary the requirement would not have been included on so many quality measure requirements for DM patients. I also routinely see chart notes of patients who were non-compliant until the beginning of retinopathy.

A. Medical consultants are reviewing the codes & policy. Stay tuned.

Pended Questions

Q. Can nurse only visits (e.g., vaccinations) be billed? How are these billed if the nurses do not get enrolled in P1?

A. Claims are billed under their supervisor's NPI.

Q. Are the services of an RN/LPN eligible for the encounter rate?

A. **IHS/638 clinics** - Nurses (RN/LPN) are not included in the list of IHS-encounter-eligible providers. Services of an RN (and any other provider who is not in the list of encounter-eligible providers) are not encounter eligible, even if under the supervision of an encounter-eligible provider (e.g. the performing NPI on the claim isn't what truly matters).

FQHC – Nurses (RN/LPN) are included in the list of providers who may provide services at an FQHC. (claims are not billed with the RN/LPN's performing NPI).

Q. What if the RN/LPN does not have a supervising provider? Nurse only visits do occur and are generally not signed off on by a provider for things such as immunizations or pregnancy tests, etc.

A. Pending research, stay tuned. All nurses have a supervising provider – the physician or the clinic. Nurses are not licensed independently (and have no NPI).

Pended Questions

Questions/comments during prior billing webinar regarding 100% FMAP

- Has the state thought about how to identify FMAP claims? What would be the incentive of having agreements with outside referring providers and the outside providers
- You can require the referring provider NPI to identify IHS facility referrals
- Will the HCA work with AIHC on developing a boilerplate care coordination agreement?
- We have issues with referrals and outside specialty providers accepting Medicaid or at their limit. It would be nice if FMAP would help with opening doors to specialty clinics. Especially with the tribes in rural areas. Can we look into increasing payment amounts for certain areas?
- Hopefully the 1115 waiver will provide a way to work this out, so outside providers can access the 100% FMAP
- When will Tribes be able to meet with the state to work on FMAP coordination? Tribes received clear instructions to work with the state to implement FMAP
- Is there a template for the FMAP Coordination of Care agreement that we can access?

Stay tuned, feel free to share comments/suggestions/ideas.

Pended Questions

Q. For next work group meeting, can we discuss the face to face requirement for encounters and how it relates to telemedicine.

A. Refer to May 16, 2015 TBWG/TCOW for more background on FFS (code) billing. Does telemedicine meet the HCA definition of *face to face?* Stay tuned.

Pended Questions

Q. Two MCO's have optical claims going to a different entity. The two subcontractors will not accept our claims or provide required subcontractor info to be able to bill. Therefore, optical claims to those two MCOs are useless.

A. Refer to slides on this attachment - *CMS Disclosure Rule 42 C.F.R. § 455.104*

Pended Questions

Q: Can ARNP (not psych) providing 'mindfulness' session bill encounter rate? See UW webpage on mindfulness-based stress reduction:

http://www.uwhealth.org/alternative-medicine/mindfulness-based-stress-reduction/11454

A. We are working on a full response. Below is a draft response:

No. The ARNP would need to be a Psych ARNP (enrolled in P1) and the client would need to be diagnosed by a licensed Mental Health Professional who indicated this treatment modality in the client's MH treatment plan.

Stay tuned

Pended Questions

Q. The MCO wraparound is not available for non-Native clients. Currently, if a client has private insurance or Medicare, they are not enrolled in an MCO, is this going to change in the future?

A. I need to split the answer up

- The MCO wraparound option for the balance of the IHS encounter rate is only for AI/AN clients.
- Beginning 01/01/2017 clients who have private insurance will be enrolled in MCO. AI/AN clients continue to have elective exemption from MCO enrollment
- Medicare dual eligible clients are not going to be enrolled in MCOs at this time

Pended Questions

- NCCI and SUD services
- Refer to 09/14/2016 TCOW slides for more information
- Claims that exceed the MUE values are rejected in P1
- DSHS/HCA is requesting an exception to NCCI rules for SUD
  - 96153 (group) MUE is 8
  - 96154 (family with client) MUE is 8
  - 96155 (family without client) MUE is 6

  Stay tuned.

Questions?

Send comments and questions to:

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If there is a difference between any information in this webinar and current agency documents (e.g. provider guides, WAC, RCW, etc), the agency documents will apply.